MALE PATIENT HISTORY

I. IDENTIFYING INFORMATION

Date _____

Name _____ Partner's Name _____

Address _____

Telephone Number - Day: ( ) _____ Evening: ( ) _____

Date of Birth _____ Partner's Date of Birth _____ Duration of Relationship _____ Duration of Infertility _____

Insurance Company _____ Insurance I.D. # _____

II. TRAVEL/WORK AND GENERAL BACKGROUND

All present employment — title(s), location, brief description, number of years employed:

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

Are you or have you ever been exposed to any of the following during employment or military service:

☐ Heat ☐ Toxic Fumes ☐ Other Specify: _____

☐ Chemicals ☐ Nuclear Radiation _____

III. MEDICAL HISTORY

	YES	NO
Weight _____ Height _____ Blood Type (if known) _____		
Have you lost greater than 20 pounds of weight in the last year?	☐	☐
Do you follow a particular food diet or have any special dietary habits?	☐	☐
If yes, specify: _____		
List the forms and frequency of regular vigorous exercise (swimming, cycling, running) and the age you began:		
Exercise: _____ Hrs/Week _____ Age _____ Exercise: _____ Hrs/Week _____ Age _____		
Do you frequently take saunas or steam baths?	☐	☐
Have you ever had surgery in the pelvic area?	☐	☐
If yes, specify date and type of surgery: _____		
Have you ever received X-rays in the pelvic area for therapy or diagnosis?	☐	☐
If yes, explain: _____		

Do you have or have you ever had (check all that apply):

☐ Anemia
☐ Appendicitis
☐ Arthritis
☐ Blood Transfusion
☐ Breast Milky Discharge
☐ Breast Soreness
☐ Breast Tenderness
☐ Cancer? Specify _____
_____
☐ Chlamydia
☐ Chronic Bronchitis
☐ Chronic Headaches
☐ Colitis
☐ Cystic Fibrosis
☐ Diabetes
☐ Dizziness
☐ Epilepsy
☐ Gallbladder Problems
☐ Gonorrhea
☐ Heart Disease
☐ Hepatitis
☐ Herpes
☐ High Blood Pressure
☐ Kidney Infection
☐ Liver Problems
☐ Loss of Balance
☐ Measles: German
☐ Measles: Regular
☐ Mumps
☐ Mumps with Testes Involved
☐ Neurological Problems
☐ Nongonococcal Urethritis
☐ Parasitic Infection
☐ Pneumonia
☐ Prostatitis
☐ Rheumatic Fever
☐ Scarlet Fever
☐ Seizures
☐ Syphilis
☐ Testes Infection
☐ Testes Injury
☐ Testes Tumor
☐ Thyroid Problems
☐ Tuberculosis
☐ Ulcers
☐ Visual Disturbances
☐ Any Allergies? List _____
_____

	YES	NO
Have you ever been treated for cancer?	☐	☐
If yes, explain therapy: _____		
Within the last year, have you taken any prescription medications?	☐	☐
If yes, list all prescriptions and problems for which you were taking them: _____		
_____		
Are you taking any over-the-counter medications on a regular basis?	☐	☐
If yes, list all medications and diagnoses: _____		
_____		
Have you had a high fever (over 102°F) during the past 3-4 months?	☐	☐

Do you use or have you ever used (check all that apply):

☐ Alcohol - How many glasses per week do you usually drink? Wine_____ Beer_____ Cocktails_____

☐ Cigarettes - Number of packs per day_____

☐ Illicit or Recreational Drugs (Marijuana, Cocaine, etc.) If you would feel more comfortable not writing anything down, please discuss this directly with your physician. Specify: _____

_____

IV. SEXUAL HISTORY

	YES	NO
Are you circumcised?	☐	☐
When you were a child, were both testes descended into the scrotum?	☐	☐
At what age did you begin shaving regularly or start to grow a beard? _____		
How many times have you been married? _____		
Have you ever produced a child with another partner?	☐	☐
If yes, how long did it take to produce a child? _____ When was this (dates)? _____		
Have you ever *tried* to produce a child with another partner?	☐	☐
Do you have trouble getting an erection?	☐	☐
Maintaining an erection?	☐	☐
Do you have trouble with ejaculations?	☐	☐
If yes, ☐ Premature ejaculations ☐ Retrograde ejaculations?		
Do you feel that some of your ejaculate is deposited in the vagina?	☐	☐
Do you ever have orgasms without ejaculation during masturbation?	☐	☐
Do you have any discharge from the penis?	☐	☐
How many times per week do you and your partner now have intercourse? _____		
How many times do you have intercourse around ovulation? _____		
Have you noticed a change in your sexual drive recently?	☐	☐

V. FAMILY HISTORY

	YES	NO
Is there a family history of infertility?	☐	☐
If yes, who (list all members and relationship to you): _____		
_____		
Is there a history of hormonal disorders in your family?	☐	☐
If yes, list who (relationship to you) and what type: _____		
_____		

VI. HISTORY OF FERTILITY THERAPY

	YES	NO
Have you been treated for infertility before?	☐	☐

If yes, who was your physician? _____

What cause of infertility was diagnosed? _____

What drugs have you taken for infertility? Check all that apply:

- ☐ clomiphene citrate (Serophene®, Clomid®)
- ☐ hMG (Pergonal®)
- ☐ tamoxifen
- ☐ testolactone
- ☐ bromocriptine (Parlodel®)
- ☐ testosterone or Male Hormone
- ☐ hCG (Profasi®, A.P.L.®)
- ☐ fluoxymesterone (Halotestin®)
- ☐ GnRH or LHRH (Factrel®)
- ☐ urofollitropin or FSH (Metrodin®)
- ☐ Other - Specify _____
- ☐ None

Have you ever had varicocele repair?	☐	☐

If yes, when? _____

Have you ever had vasectomy reversal or repair?	☐	☐

If yes, when? _____

Have you and your partner ever tried artificial insemination?	☐	☐

If yes: using ☐ your sperm? ☐ donor sperm?

Have you and your partner ever tried in vitro fertilization?	☐	☐

If yes, when and explain: _____

Which of the following tests have you had performed? Check all that apply and the results if known:

- ☐ Semen Analysis — When?_____ Results:_____
- ☐ Chlamydia Test — When?_____ Results:_____
- ☐ Mycoplasma Test — When?_____ Results:_____
- ☐ Antibody Test — When?_____ Results:_____
- ☐ Hamster Egg Test — When?_____ Results:_____
- ☐ Chromosome Test — When?_____ Results:_____
- ☐ Testicular Biopsy — When?_____ Results:_____
- ☐ X-ray or Ultrasound of Testes — When?_____ Results:_____
- ☐ Hormonal Tests (FSH, LH, prolactin, testosterone) — When?_____ Results:_____
- ☐ Thyroid Tests — When?_____ Results:_____
- ☐ Other - Specify _____ — When?_____ Results:_____

Is your partner currently seeing a doctor for evaluation of infertility?	☐	☐

If yes, specify physician name and location: _____

Does the doctor feel that your partner has an infertility problem?	☐	☐

If yes, what is the diagnosis and how is she being treated? _____

_____

Has she ever had children with another man?	☐	☐

If yes, when? _____

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VII. PHYSICAL FINDINGS

VIII. SURGERY

IX. OTHER COMMENTS

X. COURSE OF ACTION

Serono The world leader in infertility therapy
Serono Laboratories, Inc., 100 Longwater Circle, Norwell, MA 02061 (800) 283-8088 (617) 982-9000